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POLICY AND PROCEDURES FOR ENDORSEMENT OF PROVIDERS OF MEDICAID REIMBURSABLE MH/DD/SA SERVICES

North Carolina
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

I. Purpose and Overview

Purpose:
The purpose of the review of qualifications and the endorsement of Medicaid Providers is to assure that individuals receive services and supports from organizations that comply with State and Federal laws and regulations and provide services in a manner consistent with the DMH/DD/SA (Division of Mental Health/Developmental Disabilities/Substance Abuse Services) State Reform Plan. The endorsement process provides the Area Authority/County Program with objective criteria to determine the competency and quality of Medicaid Providers. This process does not apply to ICF/MR facilities, hospitals, independent practice settings or groups. Hospitals requesting to provide enhanced benefit services are subject to the endorsement process for these services. Providers seeking endorsement must be legally constituted entities capable of meeting all of the requirements of the MOA and service definitions including accreditation if applicable. Although there are a limited number of service definitions that do not require accreditation it is the intent of DHHS to eventually require accreditation for all services.

Overview:
For services that are reimbursed by Medicaid, Providers must be endorsed by an Area Authority/County Program in order to enroll with the Division of Medical Assistance (DMA) as a Medicaid Provider of an Enhanced Benefit service or services. Endorsement is a verification and quality assurance process using statewide criteria and procedures based on the NC Commission on Mental Health, Developmental Disability, and Substance Abuse Services Rules for Endorsement of Providers (10A NCAC 27G) that are currently in draft form (See Attachment 1).

Framework for Establishing Provider Qualifications:
The North Carolina Commission on Mental Health, Developmental Disabilities and Substance Abuse Services is responsible for rules establishing the requirements for the endorsement of Enhanced Benefit Providers. (Draft rules regarding Endorsement for Providers (10A NCAC 27G). These regulations will include the requirement for endorsing organizations to provide a specific service or services as a Provider of Medicaid services to MH/DD/SA consumers.

These Policies and Procedures are to be used by all Area Authorities/County Programs (excluding Piedmont). If national accreditation bodies require Area Authority/County Program to apply additional requirements to this process, those additional standards shall be required for that Area Authority/County Program. Interpretation of these Policies and Procedures shall reside with the DMH/DD/SAS.

Provider organizations that wish to provide and seek reimbursement for Medicaid covered Enhanced Benefit services must enroll directly with the DMA and are subject to Area Authority/County Program endorsement. The endorsement process is initiated by the submission of an application that contains corporate and site/service specific information. Endorsement is a prerequisite for enrollment with DMA and consists of two parts: corporate verification and site/service[1] approval. The corporate information is submitted to the Area Authority/County Program where the Provider's NC Corporate office is located. Corporate verification for this Provider will be done by that Area Authority/County Program. In the case where a provider has a corporate office outside of N.C., the corporate verification will be conducted by the Area Authority/County Program receiving the initial application for endorsement. A Provider must also seek endorsement in the catchment area in which they intend to deliver service and for the particular service they intend to provide. Endorsement is site and service specific and shall be honored by all Area Authorities/County Programs. Should a Provider that is endorsed by one Area Authority/County Program seek to provide services to consumers of other Area Authorities/County Programs, those other Area Authorities/County Programs shall verify that the Provider's endorsement is current and valid before entry into an agreement and making referrals to said Provider. Endorsed Providers will be subject to a review for re-endorsement by the endorsing Area Authority/County Program on a triennial basis.

[1] A site is a physical location where management and/or supervision occurs

II. POLICIES AND PROCEDURES FOR ENDORSEMENT OF ORGANIZATIONS AS QUALIFIED MEDICAID PROVIDERS OF ENHANCED BENEFITS

Scope:
- Applies to all Area Authorities/County Programs (excluding Piedmont)
- Applies to all organizations that wish to provide Medicaid Enhanced Benefit MH/DD/SA services

Policy for Endorsement of Qualified Providers:
Area Authorities/County Programs are required to follow policies and procedures specified in this document to ensure statewide consistency of endorsement. If the Area Authority/County Program fails to follow the policy as prescribed, Providers may initiate an appeal process within 30 days of the alleged breach. (see Appeals, Section 10)

As previously stated, endorsement is a process of qualifying a Provider to provide a specific Medicaid covered MH/DD/SA service or services. When a Provider wishes to provide services additional to those for which the Provider has a current endorsement, the Provider must request, in writing, and receive endorsement for the additional service (prior to being able to bill directly for that service). The responsibility resides with the Provider to initiate the request for endorsement for the new service. If endorsement for another service is current and valid, the Area Authority/County Program shall not review the components of endorsement common to both services, and should only review the Provider to assure the Provider is qualified to provide the new service. If the endorsement is for a Provider that is part of a multi-site Provider entity, (i.e. a Provider organization with multiple service sites and/or providing multiple services) and the larger entity is already endorsed by another, the Area Authority/County Program should only verify the currency of the endorsement by the other Area Authority/County Program, and then shall only review components of the endorsement checklist which are site-specific or service specific and have not been previously reviewed.

The endorsement process includes

1. Submission of Application (See attached application)
Services may not be authorized until the Provider is endorsed and enrolled to provide Medicaid MH/DD/SA services. The first day of the month in which the Provider's endorsement application is approved will constitute the earliest possible effective date for both referrals as well as enrollment in Medicaid.

The Provider will notify the Area Authority/County Program that it intends to provide a service and seek endorsement by scheduling an appointment to initiate the endorsement process at least six weeks prior to the submission of the endorsement application. The endorsement application packet must be submitted with return receipt to the Area Authority/County Program in which the Provider's service is located. The Area Authority/County Program will acknowledge the application via return receipt to the Provider or if the application is hand delivered the Area Authority/County Program will sign that it was received. Within 10 business days of receipt of the application the Area Authority/County Program will notify the Provider in writing if the packet is complete or if additional information is required. If additional information is needed the Provider will have 5 business days to submit the needed materials to the Area Authority/County Program. Upon receipt of the needed materials the LME will evaluate for completeness. If the needed materials are not received within the 5 business day timeline and the Provider wants to continue with the endorsement process the Area Authority/County Program will return all documents to the Provider and the Provider must resubmit the entire application packet and restart the process. If the process is restarted by resubmission of the application the Provider's position in the schedule for on-site review may be impacted

(i.e., the Area Authority/County Program may have to assign a new date for application submission based on the availability of slots). If the 5 business day timeline is met the Area Authority/County Program shall notify the Provider that the packet is complete within 2 business days.

2. On-Site Endorsement Review

An on-site endorsement review will be performed by the Area Authority/County Program within 20 business days of verification of the completed package. The Area Authority/County Program will use the standardized Endorsement Checklists during the on-site review. If in the course of the on-site review the Area Authority/County Program discovers areas that, if substantiated by Division of Facility Service (DFS) result in a Type A violation, could affect the status of the current license, the endorsement process will be suspended until DFS is satisfied that the Provider currently meets all licensure requirements and so notifies the Area Authority/County Program. The Area Authority/County Program must notify DFS within 24 hours of the on-site visit of the areas of concern. The Area Authority/County Program will notify the Provider by letter within 10 business days following the on-site review regarding the status of the endorsement review:

A. approved,
B. pended for plan of correction,
C. pended for referral to DFS –clock stops until DFS notifies Area Authority/County Program, etc.

If the status of the endorsement review is "Pended for plan of correction" because the Provider is unsuccessful in meeting the requirements for endorsement, the notification letter (referenced above) must be certified with a copy to DMH.

3. Provider Failure to Meet Requirements

The Provider will be required to submit a corrective action plan within 20 business days of notification to continue the endorsement process. Failure to submit a corrective action plan within 20 business days of notification shall result in a withdrawal of application. Upon receipt of the corrective action plan the Area Authority/County Program will have 15 business days to evaluate the information/materials submitted and make an on-site abbreviated review, if needed. Once the evaluation and on-site abbreviated review have been conducted, the Area Authority/County Program will have 5 business days to notify the Provider if the information/materials submitted are acceptable and the endorsement is approved or if the information/materials submitted are not acceptable. If the Provider information/materials are not acceptable, the Provider has 20 business days to submit a revised corrective action plan. Upon receipt of the second corrective action plan the Area Authority/County Program will have 15 business days to evaluate the information/materials submitted and make an on-site abbreviated review, if needed. Once the second evaluation and on-site abbreviated review is conducted, the Area Authority/County Program will have 5 business days to notify the Provider if the information/materials are accepted and the endorsement is approved if the information/materials submitted are not acceptable. If a Provider fails to meet corporate verification requirements, the application is denied and the Provider will be notified by certified letter (copied to the DMH). That Provider must wait six months before re-applying for endorsement at any Area Authority/County Program. A Provider that achieves corporate verification but fails to meet site/service specific requirements, must wait six (6) months to re-apply for services with the Area Authority/County Program that denied the site/service endorsement. They may, however, apply for site/service endorsement through another Area Authority/County Program at anytime. If the Provider determines that they will re-apply, the Provider must initiate the endorsement process by submitting the completed application packet to the Area Authority/County Program.

4. Conditional and Full Endorsement

The Area Authority/County Program may grant either conditional or full endorsement to a Provider applying for endorsement. Conditional endorsement shall be granted when the Provider has not previously provided MH/DD/SA services in North Carolina, or if the Provider has provided services in North Carolina previously, but has not provided the specific service for which application is being made. Conditional endorsement status may be granted for up to a six month period and may be renewed once for six more

months. The Area Authority/County Program will contact the Provider within 15 business days of the end of the conditional endorsement period to schedule an on-site review for full endorsement which follows the schedule outlined in Section 3.

Should the Provider not meet the full endorsement requirements after two six month conditional periods the Provider may not re-apply to the Area Authority/County Program for six (6) months as outlined in #3.

5. Letter of Endorsement or Conditional Endorsement

When a Provider is determined to have successfully met endorsement requirements, the Area Authority/County Program will send the Provider the standard Agreement between the Area Authority/County Program and the Provider. The Provider has 30 business days to return the agreement. Upon receipt of the agreement, the Area Authority/County Program will notify the Provider of the status of their endorsement utilizing the standard "Notification of Endorsement Action" letter. The Area Authority/County Program will notify the DMH (within 10 business days) by copy of the letter after the signed agreement between the Area Authority/County Program and the Provider has been returned to the Area Authority/County Program. The DMH will notify the DMA by copy of the "Notification of Endorsement Action" letter within 2 business days of receipt of the original letter. (See attached standard letter.)

If a conditional endorsement is issued the Area Authority/County Program will notify the DMH and the Provider utilizing the standard "Notification of Endorsement Action" letter. The letter will indicate the beginning and expiration date of the conditional endorsement. The Area Authority/County Program will notify the DMH by email copy of the letter after the signed agreement between the Area Authority/County Program and the Provider has been returned to the Area Authority/County Program. The DMH will notify DMA by email copy of the "Notification of Endorsement Action" letter within 2 business days of receipt of the original letter. (See attached standard letter). If an Area Authority/County Program conditionally endorses and does not fully endorse, the DMH will publicize the decision for conditional endorsement on it's website.

Conditional and full endorsement will be contingent upon the receipt of the signed "Agreement between the Area Authority/County Program and the Provider".
The first day of the month in which the Provider's endorsement application is approved will constitute the earliest possible effective date for both referrals as well as enrollment in Medicaid. Area Authority/County Program endorsement of the organization is required prior to the DMA's enrollment of the Provider as a Medicaid Provider.

6. Triennial Re-Endorsement Process

Providers shall be reviewed for renewal of endorsement triennially from the effective date of the full endorsement. The responsibility of initiating the re-endorsement process lies with the Provider. The re-endorsement process will be conducted every three years and will include a review of any adverse actions or sanction activity and the results of monitoring carried out by the Area Authority/County Program as specified in 10A NCAC 27G Sections .0600 - .0610. The Provider will submit an application packet as noted in #1 of this section. The application packet must be post marked at least six (6) months prior to the expiration date of the current endorsement. All the time frames that applied to the initial endorsement will also apply to re-endorsement. If the re-endorsement is for a Provider that is part of a large entity the large entity will only need to be re-endorsed by one Area Authority/County Program and the service specific sites will be re-endorsed by Area Authority/County Program service specific reviews. The Area Authority/County Program has the option to perform an abbreviated or full re-endorsement review.

Endorsed Providers are responsible for notifying the Area Authority/County Program in writing of any changes that may affect endorsement status, including but not limited to licensing sanctions, loss of accreditation, Provider management, and critical incident involving consumers, (10A NCAC 27G 0603-0604) within 30 days of the change.

7. Withdrawal of Endorsement

Withdrawal of endorsement may be initiated when:
There is evidence of substantial failure on the Provider's part to comply with current rules, including 10 NCAC 26C .0502; or
The Provider has not satisfactorily addressed, within a reasonable time period, issues that endanger the health, safety or welfare of the individuals receiving services; or
The Provider has been convicted of a crime specified in G. S. 122C – 80; or
The Provider has not made available and accessible all sources of information necessary to complete the monitoring processes set out in G.S. 122-C – 112.1; or
The Provider has not submitted the required documentation; or
The Provider has altered documents to avoid sanctions; or
The Provider has not submitted, revised or implemented a plan of correction within the specified timeframes; or
The Provider has not removed the cause of a summary suspension of DFS licensure within the specified time frame."

In cases of substantial failure to comply with current rules as noted above the Provider's corporate verification may be withdrawn and all Area Authorities/County Programs will be notified by DMH.

The Provider will be notified of the intent to withdraw endorsement via the standard "Notification of Endorsement Action" letter. The notice/letter will be signed by the Area Director and copied to the DMH and Area Authorities/County Programs statewide. (See attached letter) The DMH will issue a recommendation to the DMA to disenroll the Provider. The DMH will copy the letter to the DFS if it is a licensable service.

If the Area Authority/County Program is withdrawing endorsement of only one service and will continue to maintain endorsement for other services from the Provider, the Area Authority/County Program will amend the endorsement agreement and issue the standard letter to the provider.

If the Provider's corporate verification has been withdrawn there will be a waiting period of six (6) months before the Provider can request corporate verification from any Area Authority/County Program. If a site/service endorsement is withdrawn, there will be six (6) month waiting period before the Provider can reapply for site/service endorsement with the Area Authority/County Program that withdrew the endorsement.

The active date of Medicaid payment will stop when the DMA pulls the Provider number.

8. Agreement

The Area Authority/County Program will enter into an Agreement with an endorsed Provider. The standard Agreement and Operations Manual will contain uniform forms, provisions, and statewide requirements for all endorsed Medicaid Providers.

9. Transition Process

Due to the large number of Providers already engaged in providing services for Area Authorities/County Programs, DHHS will issue a schedule for the endorsement of Providers for each of the MH/DD/SA services. The schedule will include five phases with specific service definitions assigned to each of the phases.

10. Appeals

A Provider appeal process begins with a written appeal to the involved Area Authority/County Program and the DMH, including the date and detailed description of the disputed action and a request for review.

Resolution should first be pursued through the local Area Authority/County Program. If resolution is not reached at the local level, the appeal may be reviewed by the DMH and/or the Office of Administrative Hearings (OAH). The Area Authority/County Program is responsible for notifying the DMH about the outcome of the appeal at the local level.

- If a **new** Provider who has never been directly enrolled with DMA has an appeal concerning an endorsement that was not granted, the Provider may not bill for services until the appeal is resolved.
- For any Provider who appeals an endorsement that has been withdrawn or not renewed by the Area Authority/County Program, direct billing of that Medicaid service will be suspended until resolution of the appeal.

Outcome of each individual appeal process will determine the next course of action for the Provider or Area Authority/County Program, respectively, in regards to payback or the endorsement process.